APPENDIX C

EPA
DIVING MEDICAL
EXAMINATION

EPA Medical Evaluation
National Medical Surveillance Program

Revised
July 1997

Employee is to complete the shaded medical history section of this form prior to appointment.

Health Center - Attach hard copy of screening, diagnostic, and laboratory tests to this form prior to formal Medical Review.

Work Address: (Include BID # If Appropriate) SHEMP MANAGER:_____

_____

_____

Client SS# _____

Client Name: _____

Provider Name (s): _____

_____

Health Unit Stamp

***Periodicity of exams**
a. Conducted Annually if:
1. Over age 40
2. Known significant medical problem
3. Hazmat team member
4. Engaged in field or lab activity > 30 days per year
5. Exposure to substance mandating annual medical surveillance

b. All other exams conducted every other year

DEMOGRAPHIC DATA

Name:	**Position Title:**	**Work Phone #:**
SS#	**Date of Birth:**	**Sex:**
Date of Testing:	**Supervisor Name:**	**Supervisor Work Phone #:**

PROVIDERS PLEASE NOTE -- CORE EXAM MUST ALWAYS BE COMPLETED

PREPLACEMENT/BASELINE CORE EXAM OCCUPATIONAL HEALTH EVALUATION

Required Services: (Check when test performed)
- ☐ DFOH Profile, Blood and Urine
- ☐ Audiometry
- ☐ EKG
- ☐ Spirometry
- ☐ Vision Screening
- ☐ Chest X-Ray - PA
- ☐ General Physical Examination
- ☐ General Medical History

If indicated services: (Check when test performed)
- ☐ Stress EKG (per MRO only)
- ☐ Tetanus Immunization

*PERIODIC EXAM OCCUPATIONAL HEALTH EVALUATION

Required Services: (Check when test performed)
- ☐ DFOH Profile, Blood and Urine
- ☐ Vision Screening
- ☐ Audiometry
- ☐ General Physical Examination
- ☐ General Medical History

If indicated services: (Check when test performed)
- ☐ EKG (initially, at age 40, every 5 years thereafter)
- ☐ Stress EKG (per MRO only)
- ☐ Tetanus Immunization (every 10 years)
- ☐ Chest X-Ray - PA (initially, when medically indicated, at exit)
- ☐ Spirometry (with respirator certification, when indicated)

MEDICAL SURVEILLANCE -SPECIAL PROFILES-

Please check all specialty exams that apply and complete the testing as indicated on page 2.

- ☐ Pesticide Laboratory Workers
- ☐ Emergency Response Coordinator and On Scene Coordinator
- ☐ Field Sampling Personnel
- ☐ Clean Air Inspector/Enforcement Officers
- ☐ FIFRA Enforcement Officers
- ☐ Lab Employees
- ☐ NESHAPS/AHERA (Asbestos Enforcement Officers)
- ☐ NPDES Inspectors
- ☐ Radiation Staff
- ☐ Remedial Project Officers
- ☐ TSCA Enforcement Officers
- ☐ U.S.T. Inspectors
- ☐ Wetlands Staff
- ☐ RCRA Enforcement Officers
- ☐ EPA DIVER
- ☐ OTHERS

SPECIALTY EXAMINATIONS

☐ Pesticide Laboratory Workers
- ☐ Baseline/Exit Exam
  - ☐ Blood Lead
  - ☐ Urine Heavy Metals
  - ☐ RBC and Serum Cholinesterase
  - ☐ Respirator Clearance
- ☐ Periodic Exam
  - ☐ RBC Cholinesterase
  - ☐ Respirator Clearance

☐ Emergency Response and On Scene Coordinators
- ☐ Baseline/Exit Exam
  - ☐ RBC and Serum Cholinesterase
  - ☐ Respirator Clearance
  - ☐ Blood Lead
- ☐ Periodic Exam
  - ☐ Blood Lead
  - ☐ Respirator Clearance
  - ☐ RBC Cholinesterase

☐ Field Sampling Personnel
- ☐ Baseline/Exit Exam
  - ☐ Blood Lead
  - ☐ RBC and Serum Cholinesterase
  - ☐ Respirator Clearance
- ☐ Periodic Exam
  - ☐ Blood Lead
  - ☐ Respirator Clearance

☐ Clean Air Inspector/Enforcement Officers
- ☐ Baseline/Exit Exam
  - ☐ Blood Lead
- ☐ Periodic Exam
  - ☐ Blood Lead

☐ FIFRA Enforcement Officers
- ☐ Baseline/Exit Exam
  - ☐ RBC and Serum Cholinesterase
- ☐ Periodic Exam
  - ☐ RBC Cholinesterase

☐ Lab Employees
- ☐ Baseline/Exit Exam
  - ☐ RBC and Serum Cholinesterase
  - ☐ Blood Lead
  - ☐ Serum PCB
  - ☐ Respirator Clearance (if on emergency team)
  - ☐ Urine Heavy Metal
- ☐ Periodic Exam
  - ☐ Blood Lead
  - ☐ Respirator Clearance (if on emergency team)

☐ NESHAPS/AHERA (Asbestos Enforcement Officers)
- ☐ Baseline/Exit Exam
  - ☐ B-Reading and Chest X-Ray
  - ☐ Respirator Clearance
- ☐ Periodic Exam
  - ☐ Chest X-Ray in accordance with OSHA guidelines
  - ☐ Respirator Clearance

☐ NPDES Inspectors
- ☐ Baseline/Exit Exam
  - ☐ Core Component Only
- ☐ Periodic Exam
  - ☐ Core Component Only

☐ Radiation Staff
- ☐ Baseline/Exit Exam
  - ☐ Respirator Clearance (if on emergency response team) or as needed
- ☐ Periodic Exam
  - ☐ Respirator Clearance (if on emergency response team) or as needed

☐ Remedial Project Officers
- ☐ Baseline/Exit Exam
  - ☐ RBC and Serum Cholinesterase
  - ☐ Blood Lead
  - ☐ Respirator Clearance
- ☐ Periodic Exam
  - ☐ Blood Lead
  - ☐ Respirator Clearance (if indicated)

☐ TSCA Enforcement Officers
- ☐ Baseline/Exit Exam
  - ☐ RBC and Serum Cholinesterase
  - ☐ Blood Lead
  - ☐ Serum PCB
  - ☐ Respirator Clearance
- ☐ Periodic Exam
  - ☐ Core Component Only

☐ U.S.T. Inspectors
- ☐ Baseline/Exit Exam
  - ☐ Core Component Only
- ☐ Periodic Exam
  - ☐ Core Component Only

☐ Wetlands Staff
- ☐ Baseline/Exit Exam
- ☐ Periodic Exam
  - ☐ Core Component Only

☐ RCRA Enforcement Officers
- ☐ Baseline/Exit Exam
  - ☐ RBC and Serum Cholinesterase
  - ☐ Respirator Clearance (if on emergency response team)
  - ☐ Blood Lead
- ☐ Periodic Exam
  - ☐ RBC and Serum Cholinesterase
  - ☐ Respirator Clearance (if on emergency response team)

☐ EPA Diver
- ☐ Baseline/Exit Exam
  - ☐ Respirator Clearance
- ☐ Periodic Exam
  - ☐ EKG - Annually after age 25
  - ☐ Chest X-Ray every 2 yrs after age 40
  - ☐ If diver will be participating in NOAA diving program - completed SF 88 and 93 also attach to this exam.
  - ☐ Wrist size measured (measure in inches with cloth tape over "two knobs" above hand).

☐ Others
- ☐ Baseline/Exit Exam
  - ☐ Core Component Only
- ☐ Periodic Exam
  - ☐ Core Component Only

Client Name: _____ Date: _____

MEDICAL HISTORY

Have you ever experienced any of the following:

VASCULAR

	Yes	No
Enlarged superficial veins	☐	☐
Hardening of the arteries	☐	☐
High Blood Pressure	☐	☐
Stroke	☐	☐
Transient Ischemic Attack (TIA)	☐	☐
Aneurysms (Dilated arteries)	☐	☐
Poor circulation to hands and feet	☐	☐
White fingers with cold/vibration	☐	☐
Anemia	☐	☐

RESPIRATORY

	Yes	No
Asthma(incl. exercise induced asthma)	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Acute or chronic lung infections	☐	☐
Wind pipe or lung surgery	☐	☐
Collapsed lung	☐	☐
Scoliosis (curved spine) with breathing limitations	☐	☐
History of Tuberculosis	☐	☐

HEART

	Yes	No
Heart pain (Angina)	☐	☐
Heart rhythm disturbance	☐	☐
History of Heart Attack	☐	☐
Organic heart disease (including: prosthetic heart valves, mitral stenosis, heart block, pacemakers, Wolf Parkinson White (WPW) Syndrome)	☐	☐
Heart surgery	☐	☐
Mitral Valve Prolapse	☐	☐
Palpitations (Irregular heart beat)	☐	☐
Sudden loss of consciousness	☐	☐

Physical Activity or Exercise Program(check one)

Intensity: Low _____ Moderate _____ High_____

Activity _____ Frequency _____ Days per weeks_____

Duration _____ Minutes

DIAGNOSTIC AND PHYSICAL FINDINGS

CARDIO/PULMONARY

Normal	Abnormal	
☐	☐	EKG - Attach with interpretation
☐	☐	Lungs/Chest (includes breast)
☐	☐	Heart (thrill, murmur)
☐	☐	Vascular

Pulmonary Function Testing: (Attach Copy)

	%Predicted FVC	% Predicted FEV1	% Predicted FEV1/FVC	% Predicted FEF 25-75
(In liters)				

Comments: Findings

Circle position during test: Standing Sitting

CARDIAC RISK PROFILE:

Chol_____

HDL_____

LDL_____

Trig_____

Gluc_____

CHEST X-RAY

Last PA Chest X-ray: Date_____

Result: ☐ Normal ☐ Abnormal

Comments:_____

_____

VITAL SIGNS

Height_____ Weight_____

Blood Pressure _____ mm/hg Pulse _____/MIN

Respirations_____/MIN Temp(if indicated)_____

IMMUNIZATIONS

Tetanus (Td) Date: _____

CORONARY RISK FACTORS

	Yes	No
Blood Pressure ≥ 145/90	☐	☐
Fasting Glucose ≥ 120 mg/dl	☐	☐
Total Cholesterol ≥ 200 mg/dl	☐	☐
Family history of CVD in members ≤ 55	☐	☐
Obesity	☐	☐
No regular exercise program	☐	☐
Currently smoking or ≥ pack/yr history	☐	☐

Have you been hospitalized or had surgery in the last 2 years. Yes ☐ No ☐

If yes, please describe

_____

_____

_____

_____

_____

_____

Client Name: _____ Date: _____

MEDICAL HISTORY

WELLNESS/HEALTH PROFILE

Smoking History

This information is needed since smoking increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke.

Please check your smoking status and complete that section:

- ☐ **Never Smoked**
- ☐ **Current Smoker**
  - Number of cigarettes per day _____
  - Number of cigars per day _____
  - Number of pipe bowls per day _____
  - Total years you have smoked _____
- ☐ **Former Smoker**
  - Number of cigarettes per day _____
  - Number of cigars per day _____
  - Number of pipe bowls per day _____
  - Total years you smoked _____
- ☐ Chronic exposure to environmental tobacco smoke

Alcohol/Drug Use

What is your average alcohol consumption in a week?

_____ drinks

(1 drink = 12 0z. beer, 1 glass wine or 1.5 oz liquor)

How often do you drink alcohol?

☐ Weekdays ☐ Weekends ☐ Both

Do you use recreational drugs?

☐ Currently ☐ Previously ☐ Never

RESPIRATOR CLEARANCE QUESTIONS

☐ My position does not require the use of a respirator

(If selected do not complete this block)

☐ My position may require the use of a respirator

(If selected complete this block)

What type of respirator do/will you use:

☐ Cartridge ☐ Air Supply ☐ SCBA

How often do you use a respirator?

☐ Daily ☐ Weekly ☐ Monthly ☐ < two times a year

Effort while using respirator?

☐ Light ☐ Moderate ☐ Heavy

Hazards present during use?

☐ High altitude ☐ Temp extremes ☐ Confined spaces

Have you ever had, or do you now have any of the following? Please check all that apply and use the space below to comment on positive responses.

Yes	No	
☐	☐	Persistent Cough
☐	☐	Heart Trouble
☐	☐	Shortness of breath
☐	☐	History of fainting or seizures
☐	☐	Fear of tight or enclosed spaces
☐	☐	Sensation of smothering
☐	☐	Heat exhaustion or heat stroke
☐	☐	Contact lenses or eyeglasses
☐	☐	Other conditions that might interfere with respirator use or result in limited work activity

Client comments regarding positive responses to Respirator Clearance Questions:

_____

U.S. EPA DIVER QUESTIONS

List Type or Types of Breathing apparatus/regulators used while diving:

_____

_____

Level of Work Effort (Circle one):

Light Moderate Heavy Strenuous

Extent of Usage:

1. On a daily basis
2. Occasionally - but more than once a week
3. Rarely - or for emergency situations only

Length of time of Anticipated Effort in Hours: _____

Special Work Considerations (i.e., extra cold water, polluted water, deep diving, etc

_____

DIVING HISTORY

How many dives (wet) do you perform per year (on average)_____

How many chamber dives per year?_____

How deep do you dive, on average?_____

Do you perform moderate or heavy physical labor at depth?

Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always ☐

History of:

Decompression sickness_____

Arterial gas embolism_____

Ear barotrauma_____

Pulmonary barotrauma_____

Marine envenomation_____

Disease due to exposure to cold, heat_____

ENDOCRINE

	Yes	No
Diabetes (insulin requiring)	☐	☐
Diabetes (non-insulin requiring)	☐	☐
Childhood Onset Diabetes	☐	☐
Thyroid Disease	☐	☐
Obesity	☐	☐
Unexplained weight loss or gain	☐	☐

OBSTETRIC

	Yes	No
Are you currently pregnant?	☐	☐

Have you ever been restricted in your diving duties due to a medical condition?

Explain:

Have you ever required hyperbaric oxygen therapy?

Explain:

MENTAL HEALTH

	Yes	No
Depression	☐	☐
History of psychosis	☐	☐
Poor adaptation to stress	☐	☐
Anxiety or phobia disorder	☐	☐
Panic attacks, hyperventilation	☐	☐
Uncontrollable rage	☐	☐
Claustrophobia	☐	☐
Diagnosed personality disorder or neuroses	☐	☐

DERMATOLOGY

	Yes	No
Sun sensitivity	☐	☐
Allergic dermatitis to rubber	☐	☐
History of chronic dermatitis	☐	☐
Active skin disease	☐	☐
Moles that change in size or color	☐	☐

Medications: List all medications (prescription and over-the-counter) you are currently taking.

_____

_____

_____

Allergies: _____

_____

MEDICAL HISTORY			DIAGNOSTIC AND PHYSICAL FINDINGS	
MUSCULOSKELETAL	Yes	No	Normal Abnormal	Comments/Findings:
Moderate to severe arthritis, tendonitis	☐	☐	☐ ☐ Upper extremities (strength)	
Amputations	☐	☐	☐ ☐ Upper extremities (range of motion)	
Loss of use of arm or leg	☐	☐	☐ ☐ Lower extremities (strength)	
Aseptic bone necrosis	☐	☐	☐ ☐ Lower extremities (range of motion)	
Chronic back pain (back pain associated with neurological deficit	☐	☐		
NEUROLOGICAL	Yes	No	Normal Abnormal	Comments/Findings
Any neurological disease	☐	☐	☐ ☐ Cranial Nerves	
Seizures	☐	☐	☐ ☐ Cerebellum	
Spinal Cord Injury	☐	☐	☐ ☐ Motor/Sensory	
Numbness or tingling	☐	☐	☐ ☐ Deep Tendon reflexes	
Head/spine surgery	☐	☐	☐ ☐ Mental Status Exam	
History of head trauma with persistent deficits	☐	☐		
Chronic recurring headaches (migraine)	☐	☐		
Brain tumor	☐	☐		
Loss of memory	☐	☐		
Insomnia (difficulty sleeping)	☐	☐		
GASTROINTESTINAL	Yes	No	Normal Abnormal	Comments/Findings
Esophageal diverticula	☐	☐	☐ ☐ Auscultation	
Severe reflux	☐	☐	☐ ☐ Palpation	
Hiatal hernia	☐	☐	☐ ☐ Organo-megaly	
Gas bloat syndrome	☐	☐	☐ ☐ Tenderness	
Gastric outlet obstruction	☐	☐	☐ ☐ Inguinal hernia	
Ileostomy obstruction	☐	☐		
Diverticulitis	☐	☐		
Hernias	☐	☐		
Fistulae	☐	☐		
Colostomy	☐	☐		
Hepatitis	☐	☐		
Active ulcer disease	☐	☐		
Irritable bowel syndrome	☐	☐		
Rectal bleeding	☐	☐		
Vomiting blood	☐	☐		
GENITOURINARY	Yes	No	Normal Abnormal	Comments/Findings
Blood in urine	☐	☐	☐ ☐ Urogenital exam	
Difficult or painful urination	☐	☐		
Infertility (difficulty having children)	☐	☐		

MEDICAL HISTORY

VISION

	Yes	No
Frequent headaches	☐	☐
Blurred vision	☐	☐
Difficulty reading	☐	☐
Eye disease	☐	☐
Eyeglasses	☐	☐
Contact lenses	☐	☐
Radial Keratotomy	☐	☐
Cataracts	☐	☐
Color blindness	☐	☐

HEARING

	Yes	No
Loud, constant noise or music in the last 14 hours	☐	☐
Loud, impact noise in past 14 hours	☐	☐
Ringing in the ears	☐	☐
Difficulty hearing	☐	☐
Ear infections or cold in the last 2 weeks	☐	☐
Dizziness or balance problems	☐	☐
Are you in a Hearing Conservation Program	☐	☐
Do you use protective hearing equipment	☐	☐

If yes, type: ☐ foam ☐ pre-mold/plugs ☐ ear muffs

	Yes	No
Have you had prior Military Service	☐	☐
Have you had prior ear surgery	☐	☐
Have you had an ear drum rupture	☐	☐
Have you had recurrent ear infections	☐	☐
Do you wear a hearing aid	☐	☐

DIAGNOSTIC AND PHYSICAL FINDINGS

Head and Neck

Normal Abnormal

- ☐ ☐ Head, Face, Neck (thyroid), Scalp
- ☐ ☐ Nose/Sinuses
- ☐ ☐ Mouth/Throat
- ☐ ☐ Pupils equal/reactive
- ☐ ☐ Ocular Motility
- ☐ ☐ Ophthalmoscopic Findings

Comments/Findings

_____

_____

Vision

Normal Abnormal

☐ ☐ Color vision

Type of test

- ☐ Ishihara plate
- ☐ Function test *(Yarn, colors in room)*
- ☐ Other (specify_____)

Best corrected or native vision (Snellen Units)

Both Nr 20/_____ Right Nr 20/_____ Left Nr 20/_____

Both Fr 20/_____ Right Fr 20/_____ Left Fr 20/_____

Ears

Left

Normal Abnormal

- ☐ ☐ Canal/External ear
- ☐ ☐ Tympanic Membrane

Right

Normal Abnormal

- ☐ ☐ Canal/External ear
- ☐ ☐ Tympanic Membrane

Comments/Findings:

_____

_____

_____

Hearing

Audiogram: ☐ Baseline ☐ Annual ☐ Termination (Attach current and baseline audiogram)

Calibration Method: ☐ Oscar ☐ Biological Date_____

Frequency	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Right ear							
Left ear							

Review/compare with baseline: Change ☐ No change ☐

☐ Normal ☐ Abnormal Explain:

_____

_____

Client Name: _____ Date: _____

Occupational History

Agency - U.S. EPA	Div./Br./Sec.	Duration of employment with agency	Percent of Time in the Field/Lab

Description of Duties:

Exposures (i.e., dusts, fumes, vapors, gases, chemicals, radiation, noise, vibration, repetitive movements, temp. extremes)

Adverse Health Effects Possibly Related to Job

Other Work Performed (moonlighting, hobbies, other positions))

Any other exposures to hazardous material? ☐ Yes ☐ No If yes, explain _____

Occupational History

How long have you been doing this type of work? years

Have you ever been off work more than a day because of work-related illness or injury? ☐Yes ☐No

If "yes", specify

Have you ever changed jobs or duties due to health problems? ☐Yes ☐No

If "yes", specify

If this is your first EPA medical surveillance exam, list any previous jobs with associated hazards, starting with the one before your current position:

Agency/Company	Dates of Employment	Job Duties	Specific Hazards

Functional Activities (current position)

LEVEL A - SCBA, FULLY ENCAPSULATED SUIT, CHEMICAL RESISTANT GLOVES AND BOOTS.

LEVEL B - SCBA, CHEMICAL RESISTANT CLOTHING, CHEMICAL RESISTANT GLOVES AND BOOTS

LEVEL C - AIR PURIFYING RESPIRATOR, CHEMICAL RESISTANT CLOTHING

LEVEL D - COVERALLS, SAFETY BOOTS, GOGGLES

☐ Heavy lifting/carrying (40 lbs or more)
☐ Walking_____ hours/day ☐ Standing_____ hours/day
☐ Climbing ☐ Operation of a motor vehicle

USE OF PERSONAL PROTECTIVE EQUIPMENT

☐ Use of Level A Personal Protective Equipment
Extent of Usage: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

☐ Use of Level B Personal Protective Equipment
Extent of Usage: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

☐ Use of Level C Personal Protective Equipment
Extent of Usage: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Additional activities/comments:

Environmental Factors (last two years)

☐ Fieldwork / Approximate number of days per year: _____
☐ Labwork / Approximate number of days per year: _____
☐ Biological agents
☐ Solvents ☐ Hot Temperatures ☐ Heavy Metals
☐ Asbestos ☐ Dust ☐ Fumes, smoke, gases
☐ Radiation ☐ Excessive Noise ☐ Confined Space Entry
☐ Sewage ☐ Pesticides ☐ Cold temperatures

Additional Factors/comments:

Exposure History (current position)

Describe your work experience at major EPA work sites (up to six) during the past year.

SITE	DATE	SPECIFIC CHEMICAL AND PHYSICAL FACTORS	*EXPOSURE LEVEL	LEVEL OF PPE	SYMPTOMS FROM EXPOSURE	JOB DUTIES
1.						
2.						
3.						
4.						
5.						
6.						

*Exposure Levels
Frequency of exposure (no.# of days)
Duration of exposure (hours per day)

PROFESSIONAL STAFF Please check all the topics you discussed during the diagnostic work-up or physical examination	WORKPLACE EXPOSURE MONITORING EXAMINING PHYSICIAN	**EXAMINING PHYSICIAN** Summary of Abnormal Findings with Plan of Action
☐ Diet ☐ Low-calorie ☐ Low-fat ☐ Low-salt ☐ Cholesterol ☐ Hypertension ☐ Exercise ☐ Obesity ☐ Smoking Cessation ☐ Respirator Use ☐ Avoid Sun Exposure/Sun Screen ☐ Alcohol Use ☐ Cancer Screening ☐ Immunizations ☐ Hearing Protection ☐ Vision Referral ☐ Other Personal Protective Equipment ☐ Job Stressors ☐ Referral(s) Others_____	Is workplace monitoring data or other exposure data for this employee or this position available for review? ☐ Yes ☐ No If yes, what type of data is available? ☐ Acute Exposure Data ☐ Workplace Monitoring Data ☐ Individual Dosimetry Data ☐ MSDS ☐ Periodic Exposure Data ☐ Workplace Monitoring Data ☐ Individual Dosimetry Data ☐ MSDS	_____
	How was data made available? ☐ Electronic Database ☐ Hard Copy Report ☐ Employee Self-Report If yes, please explain what changes, if any were made in the examination due to this data: _____ Based upon your knowledge of the physical demands of the position and/or the potential exposure to occupational hazards, please answer the following: Does the employee need to continue in a medical surveillance program? ☐ Yes ☐ No ☐ Cannot determine based on information available ☐ Other	**EXAMINING PHYSICIAN TO COMPLETE:** The employee has been medically examined by me under the provisions of the EPA National Surveillance program and has been advised of the examination findings. ☐ is fully capable of participating in all job functions. ☐ is medically cleared for unrestricted respirator use ☐ is medically cleared for use of all other suitable protective equipment. (chemically resistant clothing, faceshield, glasses, gloves, earmuffs/plugs) If any of the above have not been selected please explain why, in detail, below: _____ Note: Please do not provide any official statement (oral or written) concerning the employee's fitness. The Medical Review Officer will provide a written opinion to the agency.

SIGNATURES **DATE**

I have had the examination findings explained to me and received a copy of the examination if requested. I understand the medical recommendations.

Client _____ _____

Nurse _____ _____

Physician _____ _____

ENVIRONMENTAL PROTECTION AGENCY
PHYSICAL EVALUATION FORM - EPA NATIONAL PROGRAM

TYPE OF EXAMINATION

| | PREPLACEMENT/BASELINE
| | PERIODIC
| | TERMINATION/EXIT

Results of Medical Monitoring Examination for:

Name of Client: _____ Health Center Address: _____

SSN#: _____ Region /Facility designator_____ SHEMP MANAGER:_____

Supervisor Name: _____ Phone: _____ Health Center Phone: _____

Medical Clearance Statement

The above named EPA employee has been medically examined under the provisions of the EPA National Medical Monitoring Program, and has been advised of the examination findings.

I have reviewed the employee medical history, physical examination findings and diagnostic tests.

In my opinion this employee:

_____ is medically qualified to participate in the essential functions of this position and wear all suitable respiratory protective equipment. (Level A, B, C, D).

_____ is medically qualified to wear only the indicated respiratory equipment:

☐ Negative pressure respirator ☐ PAPR respirator ☐ SCBA - type respirator ☐ Air-line respirator

_____ is medically qualified to participate in the essential functions of this position, but is not medically qualified to wear respiratory protective equipment. (Level D only)

_____ is medically qualified to participate in EPA office and or laboratory activities, but not field activities.

_____ reported no need to use respiratory protective equipment for this position.

_____ is qualified to participate in EPA field/laboratory activities with the following restrictions: _____

_____

_____ a medical recommendation can not be made at this time. Further medical evaluation, as described below, is needed: _____

_____

_____ is not medically qualified at this time for this position.

_____ is medically qualified for all EPA Diving related duties and use of breathing apparatus.

The following occupationally-related medical findings were noted during this evaluation: _____

_____

My recommendations, if any, include: _____

Reviewing Physician's Signature: _____
Date

Reviewing Physician's Name: (print/type)_____